

FILED DEC 19 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 43258

BIRTH NO. _____		REG. DIST. NO. 324		PRIMARY REG. DIST. NO. 3072		Registrar's No. 248	
1. PLACE OF DEATH a. COUNTY Saline				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY Saline 1071			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Marshall		c. LENGTH OF STAY (in this place) 10 WEEKS		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Slater		0	
d. FULL NAME OF HOSPITAL OR INSTITUTION: Fitribbons Hospital				d. STREET ADDRESS (If rural, give location) 304 West Harold Street			
3. NAME OF DECEASED (Type or Print) John		a. (First) b. (Middle) Edward		c. (Last) Cretors		4. DATE OF DEATH (Month) (Day) (Year) Dec. 9 '50	
5. SEX male		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH May, 9th 1885	
9. AGE (In years last birthday) 65		10. UNDER 1 YEAR Months Days		11. UNDER 24 HRS. Hours Mins.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Wheaton, Ill. /	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13a. FATHER'S NAME Hiram Cretors				13b. MOTHER'S MAIDEN NAME Jennie Doyle		14. NAME OF HUSBAND OR WIFE Frances Cretors	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 499-10-1202		17. INFORMANT'S SIGNATURE OR NAME Mrs. Frances Cretors	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				19. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH 2 wks ? 153X years			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Partial Intestinal Obstruction ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Tumor Mass at Cecum - possible Carcinoma DUE TO (c) Chronic Myocarditis							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Nov. 22, 1949, to Dec. 9, 1950, that I last saw the deceased alive on Dec. 9, 1950, and that death occurred at 230 P. M., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) O. A. McBurney M.D.				23b. ADDRESS Slater, Mo.		23c. DATE SIGNED 12-11-50	
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE 12/11-'50		24c. NAME OF CEMETERY OR CREMATORY Slater City		24d. LOCATION (City, town, or county) (State) Slater, Mo.	
DATE REC'D BY LOCAL REG. Dec. 11-1950		REGISTRAR'S SIGNATURE Sidney J. Gray 385		FUNERAL DIRECTOR'S SIGNATURE Hill Brothers		ADDRESS Slater Mo	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED 12.18.50
DISTRICT HEALTH OFFICE No. 3
District File Number _____
Date Filed 12.18.50

DEC 28 1950

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

A. C. Hill

Licensed Embalmer No. 3090

P. O. Address *State Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.